STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	008899	A. BUILDING _____ B. WING _____	05/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED HOSPITAL NORTHWEST INDIANA	5454 HOHMAN AVE 5TH FL HAMMOND, IN 46320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for investigation of a State hospital complaint. Complaint Number: IN00102508 Unsubstantiated: lack of sufficient evidence Date: 5/3/12 Facility Number: 008899 Surveyor: Jacqueline Brown, R.N. Public Health Nurse Surveyor Kindred Hospital of Northwest Indiana is in compliance with 410 IAC 15-1.5-6, Nursing service and 410 IAC 15-1.5-10, Utilization review & discharge planning, Indiana Hospital Licensure Rules. QA: claughlin 05/17/12	S 000		